SOUTH DAKOTA MEDICAID PROGRAM

FAMILY PLANNING MANUAL

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INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. When such changes occur, supplementary pages will be sent to participating providers. It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program rules and policies should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495

If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

PROVIDER TOLL FREE NUMBER 1-800-452-7691

Questions on Medical Assistance Program claims, covered services or eligibility verification can be directed to the above address or contact the Medical Assistance Program Provider Support Unit at *1-800-452-7691. The phone unit will not give out recipient ID numbers. The Medical Assistance Program emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID cards each time a recipient obtains services (other than true emergency services.) It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

***Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.**

Problems or questions concerning recipient eligibility requirements can be handled by contacting the local field office of the Department of Social Services in your area or should be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, South Dakota 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

CHAPTER I
GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

The Federal and state governments under Title XIX of the Social Security Act share funding and control of Medicaid. Regulations are written to comply with the actions of Congress and the State Legislature.

The following categories give a brief description of general information about the program. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

Providers who render a covered service to an eligible South Dakota Medicaid recipient, who wish to participate in the Medicaid Program must apply to become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation in the agreement and requirements stated in Administrative Rules of South Dakota (ARSD 67:16) which govern the Medicaid Program. Failure to comply with these requirements may result in monetary recovery, civil, or criminal action.

An agreement with a participating provider does not become effective until the department has approved and signed the agreement. A provider may not request reimbursement for covered services provided before the effective date, written on the provider agreement.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider can NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

An individual (i.e. employee, contractual employee, consultant etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the Medicaid Program.

TERMINATION - AGREEMENT
When a provider agreement has been terminated the Department of Social Services will not pay for services provided after the termination date. A provider agreement may be terminated for any one of the following reasons:

1. The agreement expires;
2. The provider fails to comply with conditions of participation of the signed provider agreement;
3. The ownership assets or control of the provider's entity are sold or transferred;
4. Thirty days elapse since the department requested the provider to sign a new provider agreement;
5. The provider has requested termination of the agreement;
6. Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
7. The provider has been convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare; or
9. The provider's license or certification is suspended or revoked, or
10. Due to inactivity.

OWNERSHIP CHANGE
A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The Medicaid provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

RECORDS
Providers must keep legible medical and financial records that fully justify and disclose the medical necessity and extent of services provided and billed to Medicaid. These records must be retained for at least six years after the last remittance date a claim was paid or denied. Records must not be destroyed when an audit or investigation is being conducted.

Provider must grant access to these records to agencies involved in Medicaid review or investigations.

IDENTIFICATION NUMBER
The provider identification number is a seven digit number assigned to all health care providers participating in the South Dakota Medicaid Program. This number must appear on all claims that are submitted.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because the Medicaid program is the payer of last resort, a provider must pursue the availability of third-party payment.

The department may not pay for any service that has been denied by the third-party liability source as not meeting the requirements for submitting a claim.

CLAIMS SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except for the following:

- Prenatal care for a pregnant woman;
- HCBS elderly waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under chapter 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed; or
- The claim is for services provided by a school district under the provisions of chapter 67:16:37.

The claim submitted to Medicaid must have the notice of third-party payment or rejection attached to the claim. Failure to attach the notice to <u>each</u> claim will be cause for denial of the claim.

PAYMENTS

Once the provider has identified a third-party source, he must submit his completed claim for payment of services to the third-party source before requesting payment from the department for payment. When the claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. The provider is eligible to receive the amount allowed under the department’s payment schedule less the third-party liability payment amount.

When the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

COST SHARE

Family planning services are exempt from any recipient cost share.

RECIPIENT RESPONSIBILITY

ELIGIBILITY

Eligibility for Medicaid benefits is strictly limited. Since eligibility is renewed on a monthly basis, you should always verify eligibility through the Department of Social Services Office of Medical Services.

IDENTIFICATION NUMBER

The South Dakota Medical Identification Card is issued by the Department of Social Services on behalf of eligible Medicaid recipients.

The information on the face of the card is the complete name (first, middle initial and last), RID# (recipient nine digit identification number), plus a three digit generation number, date of birth and sex.

NOTE: The three digit generation number is automatically added in the system to indicate how many cards an individual has been sent. This number is not part of the recipients ID number and should not be entered on the claim.

CLAIM STIPULATIONS

SUBMISSION

A provider must verify an individual's eligibility before submitting a claim, either through the ID card or in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under the South Dakota Medicaid Program. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for **medically necessary covered services actually provided** to Medicaid recipients eligible on the date the service is provided.

POINT-OF-SALE (POS) SUBMISSION

The South Dakota Department of Social Services has a Point-of-Sale (POS) and Prospective Drug Utilization Review (ProDUR) system for pharmacy claims.

The POS system is available 24 hours a day, seven days a week except for maintenance. Claims submitted via POS are processed in real time and may be paid, denied, reversed or captured. POS billing confirms the recipient’s eligibility on the date the prescription is dispensed.

It is important that pharmacies meet the technical requirements needed to submit claims via POS. If you are interested in submitting claims through the POS system, please have your software company contact the Department of Social Services at (605)773-3495

TIME LIMITS

The Office of Medical Services must receive a completed claim form within 12 months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

1. The claim is an adjustment or void of a previously paid claim, and is received within six months after the previously paid claim;
2. The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;
3. The claim is received within six months after a previously denied claim;
4. The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
5. To correct an error made by the department.

PROCESSING

The Office of Medical Services processes claims submitted by providers in the following manner:

1. Claims and attachments are received by the Office of Medical Services and sorted by claim type and microfilmed.
2. Each claim is given a unique fourteen digit **Reference Number**. This number is used to enter, control, and process the claim. An example of a reference number is 1998005-001468-0. The first four digit represents the number of the current year. The next three digits represent the day of the year the claim was received. The next six digits are in sequential number order of the claims received on that day.
3. The last digit represents the specific billing line on the claim (i.e. 0 would mean the first line on the claim form). Each line is considered a separate claim and is reviewed and processed using the fourteen digit reference number.
4. All claims are separately entered into the computer system and will be completely detailed on the Remittance Advice. In order for you to determine the status of a claim, you must reconcile your files with the information on the Remittance Advice.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under Federal rule 456.3, Medicaid is mandated to establish and maintain a surveillance and utilization review system (SURS). The SURS unit safeguards against unnecessary or inappropriate use of Medicaid services or excess payments, and assesses the quality of those services. Federal rule 456.23 authorizes a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers. Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by the Medicaid Program.

FRAUD AND ABUSE

The SURS unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU) under the Office of Attorney General is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD Article 67:16.

MEDICALLY NECESSARY

Medicaid covered services are only payable under Medicaid when the service is determined medically necessary by the enrolled provider. To be medically necessary, the covered service must meet all of the following conditions:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially

CHAPTER II
COVERED SERVICES AND REIMBURSEMENT

CODES TO BE BILLED ON PHARMACY CLAIM FORM

The following is a list of covered family planning services and NDC codes required for billing to South Dakota Medical Assistance Program on the pharmacy claim form.

SERVICE	NDC CODE	
Diaphragm	02510002001	EA
Foam – Cream Jellies	02510003001	EA
Male Condoms	02510004001	EA
Suppositories	02510006001	EA
Sponges	02510008001	EA
Thermometer – Basal	02510009001	EA
Depo-Provera	02510010001	per ML
Vaginal Contraceptive Film	02510011001	EA
Female Condom	02510012001	EA
Lunelle	02510013001	Vial
Ortho Evra	02510014001	EA
Nuvaring	02510015001	EA
Seasonale	02510016001	EA

NOTE: When billing South Dakota Medical Assistance Program for family planning contraceptives, be sure to use only the NDC codes listed above.

CODES TO BE BILLED ON CMS 1500 CLAIM FORM

The following are services that are to be billed on the CMS 1500 claim form.

SERVICE	**PROCEDURE CODE**
IUD – Copper	J7300
IUD – Progestacert	S4989
IUD - Insertion	58300
IUD - Removal	58301
Norplant Kit	J7306
Insertion/Reinsertion Norplant	11975
Removal Norplant	11976

NOTE: The removal of an implant is only reimbursable by the Medical Assistance Program when due to infection, rejection or when determined medically necessary. The Medical Assistance Program will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.

CODES REQUIRING FAMILY PLANNING NOTATION

The following procedure codes, if provided for a family planning service, must be indicated on the claim form. For claims submitted on the CMS 1500 claim form, the provider must put an "FP" in Block 24-H. For claims submitted electronically, the provider must include a "Y" in the family planning box.

PROCEDURE CODE	**DESCRIPTION**
99201	Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are minor
99202	Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of low to moderate severity
99203	Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate severity
99204	Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity
99205	Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician, presenting problems are minimal
99212	Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are self limited or minor
99213	Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of low to moderate severity
99214	Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity
99215	Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity
99221	Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of low severity
99222	Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of moderate severity
99223	Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of high severity

99231	Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is stable, recovering, or improving
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is responding inadequately to therapy or has developed a minor complication
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, requires two key components; patient is unstable or has developed a significant complication or a significant new problem
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99241	Office consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor
99242	Office consultation for a new or established patient, which requires three key components, presenting problems are of low severity
99243	Office consultation for a new or established patient, requires three key components, presenting problems are of moderate severity
99244	Office consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
99251	Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor
99252	Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of low severity
99253	Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate severity
99254	Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
99255	Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
99261	Follow-up inpatient consultation for an established patient, requires two components, patient is stable, recovering, or improving
99262	Follow-up inpatient consultation for an established patient, requires two components, patient is responding inadequately to therapy or has developed a minor complication
99263	Follow-up inpatient consultation for an established patient, requires three key components, patient is unstable or has developed a significant complication or a significant new problem

99271	Confirmatory consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor
99272	Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of low severity
99273	Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate severity
99274	Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
99275	Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes
99384	Initial comprehensive preventive visit, new patient, age 12-17 years
99385	Initial comprehensive preventive visit, new patient, age 18-39 years
99386	Initial comprehensive preventive visit, new patient, age 40-64 years
99394	Periodic comprehensive preventive visit, established patient, age 12-17 years
99395	Periodic comprehensive preventive visit, established patient, age 18-39 years
99396	Periodic comprehensive preventive visit, established patient, age 40-64 years

CHAPTER III
BILLING INSTRUCTIONS

The instructions in this chapter apply to paper claims only.

SUBMISSION

The original filing of claims must be within 12 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined as listed in ARSD § 67:16:35:04.

A provider may only submit a claim for services the provider knows or should have known are covered by the Medical Assistance Program.

A claim must be submitted at the provider's usual and customary charge for the service, on the date the service was provided.

The name that appears on the subsequent Remittance Advice indicates the provider name that the Medical Assistance Program associates with the assigned provider number. This name must correspond with the name submitted on claims.

Failure to properly complete provider name and address as enrolled with the South Dakota Medical Assistance Program could be cause for non-processing or denial of the claim by the Medical Assistance Program.

HOW TO COMPLETE THE PHARMACY CLAIM FORM

The following is an explanation of how to prepare the prescription drug claim form (NCPDP Universal Pharmacy Claim Form, Version DAH1-01)

NOTE: Please leave the upper right hand corner of the claim form blank. It is used by South Dakota Medicaid for control numbering.

Proper entries must be entered in the fields listed below.

ID: Enter the patient's Medicaid Identification Number is listed here. The Department uses the last nine digits of the I.D. number to process claims.

Patient Name: Enter the patient's name as it appears on the patient's Medicaid Identification Card.

Pharmacy Name: Enter the name of the Family Planning Provider as it is listed with South Dakota Medicaid.

Address, City, State, and Zip Code: Enter the address of the facility as it is listed with South Dakota Medicaid.

Service Provider ID: Enter the ten digit National Provider Identification (N.P.I.) number or seven digit identification number assigned by the Medicaid Program.

Prescription/Serv. Ref. #: Enter the provider designated number assigned to the claim to help identify individual claims.

Date of Service: Enter the date on which the product was dispensed to the patient. Dates should be listed as the following example indicates: 01-01-2005.

Quantity Dispensed: The unit quantity of the product dispensed. See Chapter II for the units listed for the Family Planning Products.

Days Supply: Enter the number of days (may be an estimate for some products) the dispensed product should last the patient based on administration directions.

Product/Service ID: Enter the NDC Code for the product dispensed. See Chapter II for a complete listing of products, which can be dispensed by Family Planning Providers.

Prescriber ID: Enter the South Dakota Medicaid assigned Prescriber Identification Number for the physician ordering the family planning item. If the prescribing physician does not have a Medicaid prescriber number, enter the physicians' last name in this field.

Usual AND Customary Charge: Enter the amount that is usually charged for the product being dispensed.

Other Payer Amount Paid: This field is only used when the patient has primary insurance coverage. If this situation occurs the claim must be billed to the primary insurance before being billed to South Dakota Medicaid. Enter the amount paid by the primary insurance in this field. South Dakota Medicaid will pay the difference of what the primary paid and the calculated Medicaid reimbursement.

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

Failure to properly complete ***MANDATORY*** requirements will be cause for non-processing or denial of the claim by the Medical Assistance Program.

THE FOLLOWING IS A BLOCK-BY-BLOCK EXPLANATION OF HOW TO PREPARE THE HEALTH INSURSANCE CLAIM FORM CMS 1500.

Please do not write or type above block 1 of the claim form. It is used by the South Dakota Medical Assistance Program for control numbering.

BLOCK 1 HEADINGS

Place an "X" or check mark in the Medicaid block. If left blank, Medicaid (Medical Assistance Program) will be considered the applicable program.

BLOCK 1a **INSURED'S ID NO. (*MANDATORY*)**
The recipient identification number is the nine-digit number found on the South Dakota Medical Assistance Program Identification Card. **The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 **PATIENT'S NAME (*MANDATORY*)**
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 **OTHER INSURED'S NAME (*MANDATORY*)**
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.
NOTE: Do not enter Medicare, PHS, or IHS

BLOCK 10 WAS CONDITION RELATED TO
A. Patient's Employment-If the patient was treated due to employment-related accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

B. Auto accident-If the patient was treated due to an auto accident, place an "X" in the in the YES block, if not, place an "X" in the NO block or leave blank. If YES, put the state abbreviation under the PLACE Line. State identifier is optional.

C. Other accident- If other type of accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

D. Reserved For Local Use-Enter one of the following, if applicable: "**U**" for Urgent Care; "**I**" for Contract Providers; "**D**" for Dental Services; or "**E**" for Emergent Managed Care Exemption Code.

BLOCK 11 **INSURED'S POLICY GROUP OR FECA NUMBER (*MANDATORY*)**
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
If the recipient was a referral, enter the referring physician's or (other sources) name. Optional, but very helpful.

BLOCK 17a/b ID NUMBER OF REFERRING PHYSICIAN
If recipient was a referral, enter the referring physician's or (other sources) seven digit South Dakota Medicaid provider number.

17a- The qualifier indicating Medicaid should be reported in the field to the immediate right of 17a. The appropriate code for Medicaid is 1d. The Medicaid ID number of the referring provider should be reported in 17a shaded area.

17b- Enter the NPI number of the referring provider.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Place an "X" in the "YES" or "NO" block. Leave the space following "Charges" blank. If not applicable, leave blank.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Diagnosis codes and descriptions 1, 2, 3, and 4 – Enter the appropriate diagnosis code(s) which best describe the reason(s) for treatment or service, listing the primary in position "1", secondary in position "2", etc.

These codes must be ICD-9 codes. "V" codes are acceptable.
"E" codes are not used by the South Dakota Medical Assistance Program.
The following claims are exempt from diagnosis code requirements:
1. Anesthesia;
2. Ambulatory Surgical Center;
3. Audiology;
4. Laboratory or pathology;
5. Therapy Services;
6. Radiology; and
7. Transportation.

BLOCK 22 MEDICAID RESUBMISSION NUMBER
Required for replacements and voids only.

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Enter the prior authorization number provided by the department, if applicable.
NOTE: Leave blank if the South Dakota Medical Assistance Program does not require prior authorization for service.

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier. The top shaded area is the location for the reporting supplemental information. **It is not intended to allow the billing of 12 lines of service.**

A. DATE OF SERVICE FROM – TO (*MANDATORY*)
Enter the appropriate date of service in month, day, and year sequence, using six digits.

	FROM	TO
Example:	01/24/04	01/24/04

B. PLACE OF SERVICE (*MANDATORY*)
Enter the appropriate place of service code.

Code values:

01	Pharmacy
03	School
11	Office
12	Home
14	Group Home
20	Urgent Care Facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

C. EMG

Enter a Y for “YES” for an emergency indicator, or leave blank if “NO” in the bottom, unshaded area of the field. For Emergent Managed Care Exemption Code if appropriate.

D. PROCEDURE CODE (*MANDATORY*)

Enter the appropriate five character Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

NOTE: Use the same procedure code only once per date of service.

E. DIAGNOSIS POINTER
Optional – you may enter 1, 2, 3, or 4 which correlates to the diagnosis code entered in Block 21. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

F. CHARGES (*MANDATORY*)
Enter the provider's usual and customary charge for this service or procedure.

G. DAYS OR UNITS (*MANDATORY*) (*if more than one*)
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. If this is left blank, reimbursement will be for one unit/time (15 minutes).

H. EPSDT – FAMILY PLANNING
Early and Periodic Screening, Diagnosis and Treatment. If services were provided because of an EPSDT referral, enter an "E" in the unshaded area of the field, if not, leave blank.

FAMILY PLANNING
Enter an "F" for any service provided for family planning visits, medication, devices, or surgical procedures in the unshaded area of the field, if not, leave blank.

I. ID. QUAL
Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. For Medicaid the qualifier code will be 1d in the shaded area.

J. RENDERING PROVIDER ID #
Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 YOUR PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.
Examples: AMX2345765, 9873546210 and YNXDABNMLK
NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.
NOTE: The South Dakota Medical Assistance Program can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 **AMOUNT PAID (*MANDATORY*)**
If payment was received from private health insurance, enter the amount received here. (Attach a copy of the Insurance Company's Remittance Advice or explanation of benefits behind each claim form.) The Division of Medical Services will allocate that payment to each individual line of service as necessary. If payment was denied, enter 0.00 here (attach a copy of insurance company's denial).
NOTE 1: Do not subtract the other insurance from your charge.
NOTE 2: Medicaid's Cost Sharing (recipient's payment), if applicable is not considered a payment from other source – do not enter on claim.

BLOCK 30 BALANCE DUE
Optional

BLOCK 31 **SIGNATURE OF PHYSICIAN OR SUPPLIER (*MANDATORY*)**
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without signature and date completed.

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Optional
32a Enter the NPI number of the service facility location.
32b Enter the two digit qualifier followed by the Medicaid ID number. For Medicaid the qualifier code is 1D.

BLOCK 33 **PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (*MANDATORY*)**
Enter the billing provider's name as listed on the South Dakota Medical Assistance Program Provider file with the complete address. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.
ID NO. (*MANDATORY*)
33a Enter the NPI number of the billing provider.
33b Enter the two digit qualifier followed by the Medicaid ID number. For Medicaid the qualifier code is 1D.

SUBMITTING VOID AND REPLACEMENT REQUESTS

Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number. In other words, all lines submitted on a single claim form will have a single claim reference number assigned to them.

The necessary processing is described in detail below. These procedures are intended to result in less work for the provider's staff and quicker processing of claims through the Medical Assistance Program payment system.

VOID REQUEST

A void request instructs the Medical Assistance Program to reverse all the money paid on a claim. Every line is reprocessed. A paid line has the payment reversed. A denied line remains denied. A pending line is denied. The transaction is shown on the Remittance Advice as a payment deduction from payment that may be due.

To submit a void request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the word "VOID" at the left;
- In the same field, enter the claim reference number that the Medical Assistance Program assigned to the original claim, at the right;
- Highlight field 22;
- Send the void request to the same address you have always used; and
- Keep a copy of your request for your files.

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your Remittance Advice as an error.
Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line on the original claim and processed. This part of the transaction works as described in void processing, above. The corrections you supply are entered and the entire claim is reprocessed. A paid line can be increased or decreased. A denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. The transaction is shown on your Remittance Advice and changes in payment are added to or deducted from any payment that may be due to you.

To submit a replacement request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the word **REPLACEMENT** at the left;
- In the same field, enter the claim reference number that the Medical Assistance Program assigned to the original claim, at the right;
- Highlight field 22;

• Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and replace with correct information;
• Highlight all the corrections entered;
• **Do not** attach additional separate pages or use post-it notes. These may become separated from the request and delay processing;
• Send the replacement request to the same address you have always used; and
• Keep a copy of the request for the required time.

An original claim can be replaced only once. The provider may, however, submit a void or replacement request for a previously completed replacement. In this case, enter VOID or REPLACEMENT (as appropriate) in field 22 at the right and indicate the claim reference number of the replacement claim at the left. Highlight field 22, enter and highlight any corrections, as described above, and submit the request.

The Medical Assistance Program claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

CHAPTER IV
REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from the Medical Assistance Program. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current status of all claims, (including replacements and voids) that have been processed during the past week are shown on the Remittance Advice. It is the provider's responsibility to reconcile this document with patient records. The Remittance Advice documents all payments and denials of claims and should be kept for six years, pursuant to SDCL 22-45-6.

SAMPLE REMITTANCE ADVICE

BILL SMITH, MD
111 10 AVE SW
ABERDEEN SD 57401-1846

PHYSICIAN REMITTANCE ADVICE
11/01/2006

DEPT. OF SOCIAL SERVICES
MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE,, SOUTH DAKOTA 57501-2291

PAGE NO. 1

PROVIDER NO: 5601111 FED TAX ID NO.: 123456789 NPI:

THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:

REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENTNAME	FROM DATE	THRU DATE	PROCEDURE CODE MODIFERS	NUM SER	PL SER	BILLED CHARGES	LESS PAID	COST SHARE	PAID BY PROGRAM
2006300-711100-0	000222111	DOE, JANE A	10-10-06	10-10-06	58300	1		116.00	.00	.00	103.00
PAT ACCT NO. 01122222											
TOTAL APPROVED ORGINALS:	1							116.00			

PHYSICIAN CLAIM TOTAL 103.00
REMITTANCE TOTAL 103.00
YTD NEGATIVE BALANCE .00
MMIS REMIT NO: 71122334 AMOUNT OF CHECK $103.00

IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE. PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES

REMITTANCE ADVICE FORMAT

Each claim line is processed separately.
Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim.
The following information explains the Remittance Advice format:
HEADER INFORMATION:

- Medical Assistance Program address and page number;
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date; and
- Provider name, address, and Medical Assistance Program provider ID number.

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES:
The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **READ CAREFULLY ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURSE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

APPROVED ORIGINAL CLAIMS
A claim is approved and then paid if it is completely and correctly prepared for a Medical Assistance Program covered service(s) provided to an eligible recipient by a Medical Assistance Program enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by Medical Assistance Program.

DEBIT REPLACEMENT CLAIMS
A replacement can be processed only for a claim that has previously been paid. When replacing a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.
NOTE: Once you have replaced a claim you cannot replace or void the original claim again.

CREDIT REPLACEMENT CLAIMS
This is the other half of the replacement process. The reference number represents the original paid claim. Information in this section reflects the Medical Assistance Program processing of the original paid claim. This information is being replaced by the correct information, listed in the section above (THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS).

VOIDED CLAIMS
This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.
NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS
A claim is denied if one or more of the following conditions exist:

1. The service is not covered by the Medical Assistance Program;
2. The claim is not completed properly;
3. The claim is a duplicate of a prior claim;
4. The data is invalid or logically inconsistent;
5. Program limitations or restrictions are exceeded;
6. The service is not medically necessary or reasonable; and
7. The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or the Medical Assistance Program policy.

Claims that cannot be paid by Medical Assistance Program are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY
When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed. There is no identifying information on the Remittance Advice explaining for which recipient or services this payment is made for, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL
The total amount is determined by adding and subtracting all of the amounts listed under the column **PAID BY PROGRAM.**

YTD NEGATIVE BALANCE
A Year-to Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit replacement and void claims, is larger than the total amount of positive transactions (original paid and debit replacements), a negative balance will be shown.

MMIS REMIT NO ACH AMOUNT OF CHECK
The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

PENDED CLAIMS – THE FOLLOWING CLAIMS ARE PENDED FOR REVIEW – PROVIDER DOES NOT NEED TO TAKE ACTION UNLESS FURTHER CONTACT IS MADE:

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY THE MEDICAL ASSISTANCE PROGRAM AT 1-800-452-7691 AS SOON AS POSSIBLE.

CHAPTER V
MEDICAL IDENTIFICATION CARD

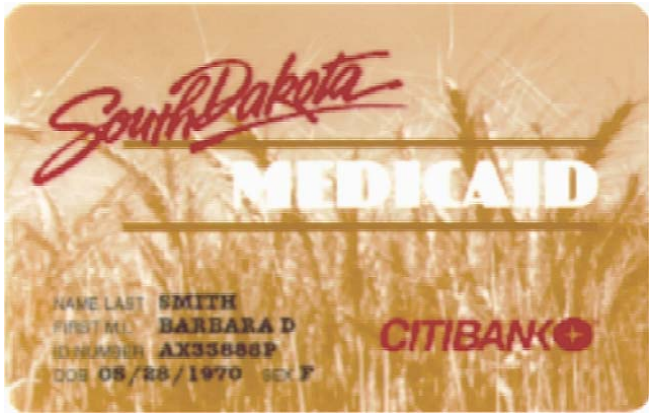
The South Dakota Medical Identification Card is issued by the Department of Social Services on behalf of eligible Medicaid recipients.

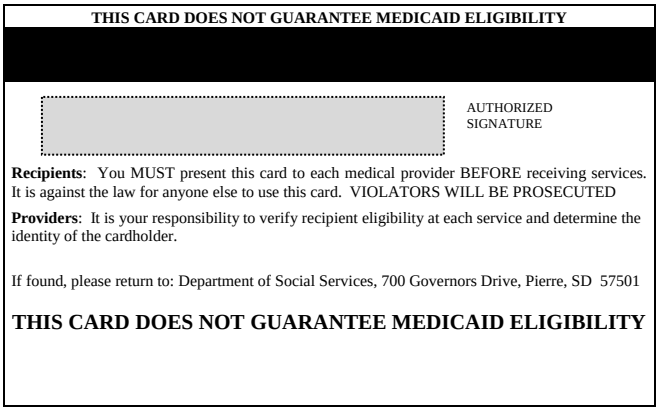
The magnetic stripe card has the same background as Food Stamp EBT card. The information on the face of the card will be the complete name (first, middle initial and last), RID# (recipient identification number 9 digits) plus a three digit generation number, date of birth and sex.

Note: The 3-digit generation number is automatically added in the system to indicate how many cards an individual has been sent. This number is not part of the recipient's ID number and should not be entered on the claim.

Each card has only one name on it. There are no family cards.

A recipient must present their Medicaid identification card to a Medicaid provider each time, before obtaining a Medicaid covered service. Failure to present their Medicaid identification card is cause for payment denial. Payment for such denied service becomes the responsibility of the recipient.




THIS CARD DOES NOT GUARANTEE MEDICAID ELIGIBILITY

AUTHORIZED SIGNATURE

Recipients: You MUST present this card to each medical provider BEFORE receiving services. It is against the law for anyone else to use this card. VIOLATORS WILL BE PROSECUTED

Providers: It is your responsibility to verify recipient eligibility at each service and determine the identity of the cardholder.

If found, please return to: Department of Social Services, 700 Governors Drive, Pierre, SD 57501

THIS CARD DOES NOT GUARANTEE MEDICAID ELIGIBILITY

HOW THE CARD WORKS

Medicaid eligibility verification system (MEVS) is a process by which the provider can access the state's eligibility file electronically.

There are three ways a provider can access eligibility information:

(1) *Point of Sale Device:* Through the magnetic strip, the provider can swipe the card and in about 10 seconds have an accurate return of eligibility information.

(2) *PC Software:* The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.

(3) *Automated Voice Response:* The provider who does not purchase equipment to access the plastic card will need to call the Office of Medical Services' 1-800 and receive eligibility information through the Automated Voice Response. This process takes approximately 1:15 minutes to complete a transaction and is only capable of reporting current (no previous) eligibility information.

Note: It is important to listen to the entire message when calling the Voice Response system.

ELIGIBILITY INFORMATION RECEIVED THROUGH THE MEVS

Through the MEVS (swipe or PC key entry) the provider will receive a "receipt ticket" in their office immediately upon eligibility verification (10 Seconds). The following is an example of the "ticket' sent to the provider.

**********SD MEDICAID**********
Eligibility
01/19/98 14:44:58
Date of Service: 01/19/98
Provider ID #: 0100150
**********Individual Status**********
Verification Number 19980119144313
Name: June Doe
RID#: 000123788
Card Generation #: 001
DOB/(age): 01/29/1976(21)
Sex: F
Restriction: LIMITED TO PREGNANCY SERVICES
Co-Pay: N
**********Managed Care**********
Managed Care: Y/N
PCP Name: Dr. John Physician
PCP Telephone # 605-999-1234
**********Third Party Liability**********
Medicare/HIB# 123-45-6789A
Coverage code PHI--3
Policy Number:AA1234
Carrier Name: Hartford
Address: 123 S. Main
City/State/Zip Hartford, CT. 12345
Phone # 605 123-4567

Certain Medicaid recipients are restricted to limitations of covered services. It is very important that you check for restrictions.